Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-2806-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration stating that according to Texas Labor Code 1305.006, health care provided by an out –of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103. Appeal was reviewed, however the carrier stud by their original decision."

Amount in Dispute: $504.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a network claim but the facility is not in the HCN and referral for treatment outside the network was not authorized by the network."

Response Submitted by: Liberty Mutual, Carol Crewey

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2010	Outpatient Hospital Services	$504.09	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - PROVIDER IS NOT WITHIN THE LIBERTY HEALTH CARE NETWORK (HCN) FOR THIS CUSTOMER. TX INSURANCE CODE 1305.004 (B) AND LABOR CODE 401.011.

- X652 RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED.

Issues

1. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.305 and §133.307?

Findings

1. This dispute was filed at the Texas Department of Insurance, division of Workers' Compensation (Division), Medical Fee dispute Resolution section on April 15, 2011 for resolution pursuant to 28 Texas Administrative Code §133.307.
2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care not delivered,or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules…" 28 Texas Administrative Code §133.307(a)(1) similarly states that "this section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care…" Therefore, pursuant to 28 Texas Administrative Code §133.305, and §133.307, the Division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.
3. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. Insurance Code Chapter 1305, section 1305.103 (e) states in part "Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested…" Review of the documentation supports that the injured employee is enrolled in a certified health care network, but no documentation was found to support that the health care in dispute is authorized, out-of-network care pursuant to Insurance Code Chapter 1305. Therefore, the dispute may not be resolved pursuant to 28 Texas Administrative Code §133.307, and medical fee dispute resolution is not the appropriate venue for resolution of the dispute filed by the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 05, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.